

**Medical Massage Center of Anytown
123 Anystreet
Anytown, USA 11111
(123) 456-7890**

PHYSICIAN'S PRESCRIPTION

Patient Name _____

Date _____

Diagnoses _____

Frequency & Duration of Treatment _____

Specific Goals _____

Precautions _____

- Evaluate & Treat
- Physical Therapy

- Occupational Therapy
- Treat only as specified Below**

Modalities & Procedures

- Hot Packs/Cold Packs
- Ultrasound Electrical
- Stimulation Ultrasound/E-Stim
- Vasopneumatic Compression/Cold
- Traction (Cervical / Pelvic)
- Paraffin
- Fluido Therapy
- Iontophoresis / Phonophoresis
- Neuromuscular Re-Education
- Whirlpool
- T.E.N.S. (Rental/Purchase)
- E.M.S. (Rental/Purchase) Manual Techniques

Special Programs

- Hand Therapy Program
- McKenzie Eval / Rehab
- Patellofemoral Rehab
- McConnell Taping / Supplies
- Athletic Rehab (Sport Specific)
- Pre Operative / Post Op Program
- ACL Rehabilitation
- Zuni Unloading
- Thoracic-Outlet Syndrome Rehab
- Aquatic Rehab Program
- Pregnancy (Pre/Post Natal Care)
- Isokenetic Evaluation / Rehab.

Manual Techniques

- Massage / Soft Tissue Mobilization
- Joint Mobilization
- Manual Stretching
- Spray & Stretch
- Myofascial Release
- Muscle Energy-Strain Counter-Strain

Joint Rehabilitation

- Knee
- Shoulder TMJ
- Ankle Hand Therapeutic Exer.
- Elbow Home Program
- Hip Directed Gym Program
- Wrist

Additional Comments

This prescription is an evaluate and treat order unless specified otherwise above.
I CERTIFY THAT THE ABOVE TREATMENT PLAN IS MEDICALLY NECESSARY AND IS APPROVED.

Physician Signature _____
(this must be signed by Doctor in order for you to receive treatment)

Physician NPI#: _____

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